MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01498

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester.
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester.
City or town Berlin,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Brown Bethards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Arabanta Bethards
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1866

8. AGE: Years	Months	Days	If less than one day
80	3	13	...hrs. ...min.

9. Birthplace Berlin, Wor. Co. Md.
(Town, county, and state)
10. Usual occupation Carpenter.
11. Industry or business
FATHER 12. Name William Bethards
13. Birthplace Maryland.
MOTHER 14. Maiden name Mary Anne Burbage
15. Birthplace Maryland.
16. Informant Mrs. C. B. Bethards.
Address Berlin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/47 (month) (day) (year)
Cemetery or crematory St Pauls Churchyard
Location Berlin Md
18. Funeral director Emma A. Burbage
Address Berlin Md
19. 4-5- 1947 Helen F. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 8:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-20 1947 to 4-3 1947 and that I last saw h...m...alive on 4-2-47 1947

Immediate cause of death	DURATION
Hypo static Pneumonia	
Due to Pneumococcus Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other
Address Berlin Md. Date signed 4-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

01499

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Whaleyville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

X

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Whaleyville

(If outside city or town limits, write RURAL and give nearest town)

Street No. none

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY PETER DALE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: — X —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept 12 1870

8. AGE:

Years	Months	Days	If less than one day
76	7	11	____ hrs. ____ min.

9. Birthplace: Whaleyville, Md. (Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Carpenter

FATHER — 12. Name: Peter Dale

13. Birthplace: Md.

MOTHER — 14. Maiden name: Jane Mumford

15. Birthplace: Md.

16. Informant: Harriett Whaley

Address: Whaleyville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1947 (month) (day) (year)

Cemetery or crematory: Dale Family Cemetery

Location: Whaleyville, Md.

19. Funeral director: M. Parks Watson

Address: Selbyville, Del.

19. 4-26-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947, at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 20 1947, to day of death 19.... and that I last saw him alive on 4-23-47 19....

Immediate cause of death	DURATION
Myocarditis Chronic	3 yrs
Due to	
Due to	
Other conditions Hypertension.	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Frank R. Lines M. D. (M. D. or other)

Address: Willards Md. Date signed 4-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

01500

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Rural Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Rural Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: William Dennis

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Hester Dennis

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): July 1, 1873

8. AGE:

Years	Months	Days	If less than one day
73	9	16	... hrs. ... min.

9. Birthplace: Pocomoke, Worcester, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER — 12. Name: Isaac Dennis

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Andrew Dennis

Address: Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 21-1947 (month) (day) (year)

Cemetery or crematory: Unionville Cemetery

Location: Rural Pocomoke Md.

18. Funeral director: Henry L. Watson

Address: Pocomoke Md

19. April 21, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from June 18, 46 to April 16 1947

and that I last saw him alive on April 16, 1947

Immediate cause of death: Criteria-sclerotic Cardio Vascular Renal Disease — DURATION: 3 Yrs.

Due to: Senility

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis L. Llewellyn M.D.

Address: Pocomoke City Date signed: 4/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01501

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35-1

1. PLACE OF DEATH:
County: Worcester Md
City or town: Snow Hill R.F.D. No 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twenty four years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Near Snow Hill R.F.D. No 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Sallie Frances Elwell

3.(b) Social Security Number: ~~no~~ 213-12-5702

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a. a.	married

6.(b) Name of husband or wife: William E. Elwell
6.(c) If alive, give age: yes Don't know years

7. Birth date of deceased (mo., day, yr.): about 1895

8. AGE: Years: about 52 | Months: — | Days: — | If less than one day: ...hrs. ...min.

9. Birthplace: Pemberton Wicomico Co Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER
12. Name: Joshua Williams
13. Birthplace: Pemberton Wicomico Co Md

MOTHER
14. Maiden name: Martha Bivans
15. Birthplace: Pemberton Wicomico Co Md

16. Informant: William E. Elwell
Address: Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13 1947 (month) (day) (year)
Cemetery or crematory: Parks
Location: near Snow Hill Md

18. Funeral director: James H. Stewart
Address: Salisbury Md

19. 4/11/47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1947 at 8:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1945 to April 8 1947 and that I last saw her alive on April 6 1947

Immediate cause of death	DURATION
Pulmonary Hemorrhage	1 Hr.
Due to: Pulmonary Tuberculosis	7 yr
Due to:	
Other conditions: Thoracoplasty 1944	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Robert L. LaMar MD
M. D. or other
Address: Snow Hill, Md. Date signed 4-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01502

CERTIFICATE OF DEATH

Reg. Dist. No. 357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

WITHIN CORPORATE LIMITS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) 70
2.(a) If veteran, name war

3. (a) FULL NAME E. Vance Fooks

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Kattie M. Fooks
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct. 26 - 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	5	13		

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Dewitt Fooks
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Ann Sheehy
15. Birthplace: Maryland
16. Informant: Mrs. E. Vance Fooks
Address: 504 Roosevelt St. Bethesda, Md
17. Burial, cremation, or removal: Buried Date thereof: April 12 1947 (month) (day) (year)
Cemetery or crematory: Presbyterian
Location: Snow Hill Md
18. Funeral director: Elder & Timmis
Address: Snow Hill Md
19. (Date rec'd by registrar) 4/12/1947 R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1947 at 6:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 19.. to April 9 1947
and that I last saw him alive on April 9 1947
Immediate cause of death: Acute Pulmonary Edema — DURATION: 2 wks
Due to: Hypertensive Cardiovascular Renal disease — 3 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar M.D. M. D. or other
Address: Snow Hill Date signed: 4-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3a)

CERTIFICATE OF DEATH

01503

Reg. Dist. No. 3-56

1. PLACE OF DEATH:
County Worcester.
City or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World war #1

3. (a) FULL NAME Daniel Henry Gordon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Dorothy Gordon
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1893

8. AGE: Years	Months	Days	If less than one day
53	5	16	...hrs. ...min.

9. Birthplace Ocean City Md.
(Town, county, and state)
10. Usual occupation Boardwalk Concession
11. Industry or business

FATHER
12. Name William Gordon.
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Margaret Trumpen
15. Birthplace Balto. Md.

16. Informant Mrs. D. H. Gordon.
Address Ocean City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/47 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md
18. Funeral director Anna E. Bunting
Address Berlin, Md

19. 4-9- 19 47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47 at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 46 to April 7 19 47 and that I last saw h...alive on Apr 7 19 47

	DURATION
Immediate cause of death Pulmonary Edema	
Due to Heart failure	
Due to Cerebral Hemorrhage	3 days
ON basis of unknown CNS Lesion	1 Indef.
Other conditions Epilepsy - 15 years.	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Townsend, Jr. M.D. M. D. or other
Address Ocean City, Md. Date signed Apr 9, 47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d) 01504 35-7

Reg. Diat. No. .....

1. PLACE OF DEATH.
County WORCESTER
City or town STOCKTON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town STOCKTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES BURTON HALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widower

6.(b) Name of husband or wife LOLA SPENCE HALL
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 69 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace DEL.
(Town, county, and state)
10. Usual occupation LABORER - lumbering
11. Industry or business

FATHER
12. Name GEO. BURTON HALL
13. Birthplace DELAWARE

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN

16. Informant JAMES HALL son
Address STOCKTON

17. BURIAL
(Burial, cremation, or removal. Which?)
Date thereof Apr 14 1947
(month) (day) (year)
Cemetery or crematory Home Beneficial
Location Stockton Md.
Irvin Bennett
18. Funeral director
Address Stockton Md.

4-14-47 MARY M. TAYLOR
19. ..... 19..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947 4-05 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to April 11 1947 19.....
and that I last saw h..... im alive on April 7 1947 19.....

	DURATION
Immediate cause of death	
HYPERTENSIVE CARDIO VASCULAR	
Due to DISEASE	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul Green M. D. or other
Address Snow Hill Date signed 3/5/47

REPLACEMENT cer. for one in Apr. drawer, see also corres. pending at front desk.
VS A16 9-45-15M
MARGIN RESERVED FOR BINDING
Ll 1-14-47 CORRES. FILED UNDER HALL 5-8-47 LL
also replaced cer. filed 5-8-47 G
PLEASE WRITE PLAINLY, WITH INK. Supply every item of information. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01505

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin R.F.D. No 3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) no
2.(a) If veteran, name war

3. (a) FULL NAME Calvert H. Henry

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a. a.	widowers

6.(b) Name of husband or wife: Mary Henry Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years: 46 | Months: — | Days: — | If less than one day: hrs. min.

8. Birthplace: Berlin Md (Town, county, and state)
10. Usual occupation: Chef
11. Industry or business: Same as above
FATHER 12. Name: John Henry
13. Birthplace: Berlin Md
MOTHER 14. Maiden name: Margaret E. Powell
15. Birthplace: Berlin, Md.
16. Informant: Edmund Henry
Address: Berlin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 20 1947 (month) (day) (year)
Cemetery or crematory: Tyre
Location: Berlin md
18. Funeral director: James H. Stewart
Address: Salisbury md
19. 4-20- 1947 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947, at 7 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Apr. 1947, to 18 Apr. 1947
and that I last saw him alive on 18 Apr. 1947

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Mesaortitis Luetic	2 yrs
Due to:	
Other conditions: Anuerism-aortic	
due to above	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hadden Shepard M. D. or other
Address: Berlin, Md Date signed: 4-21-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

01506

CERTIFICATE OF DEATH

Reg. Dist. No. 354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Baby Jacobs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 26 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	0	1 hrs. ..... min.

9. Birthplace: Stockton
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Randolph Dashiells
13. Birthplace: Snowhill

MOTHER
14. Maiden name: Etta M. Jacobs
15. Birthplace: Stockton

16. Informant: Etta M. Jacobs
Address: Stockton

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 27 1947 (month) (day) (year)
Cemetery or crematory: J. W. Truman cemetery
Location: Stockton Md

18. Funeral director: Grace Bennett
Address: Stockton Md

19. Apr. 27 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 26 1947, at 11:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Premature Birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed 4/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01507

Reg. Diat. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mamie Jane Justice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Col	widowed

6.(b) Name of husband or wife: Isaac Justice
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 15 - 1882

8. AGE: Years	Months	Days	If less than one day
65	2		..... hrs. ..... min.

9. Birthplace: Pocomoke City Worcester Co Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: George Anderson
13. Birthplace: Pocomoke City Worcester Co
MOTHER 14. Maiden name: Mary Jane Wright
15. Birthplace: Pocomoke city Worcester Co
16. Informant: Gordon Justice
Address: Pocomoke City Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 21 1947 (month) (day) (year)
Cemetery or crematory: Mount Zion
Location: Pocomoke City Md.
18. Funeral director: Charles H Ward
Address: Marion Md.
19. April 20 1947 (Date rec'd by registrar) Anne E White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 April 1949 at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 August 1947 to 15 April 1947 and that I last saw her alive on 12 April 1947

Immediate cause of death: (1) Pneumonia, lobar, right (2) Pericarditis, acute (3) Hypertensive cardiovascular disease.
Due to: (4) Generalized Arteriosclerosis, mod.
Due to:
Other conditions: Paralytic Stroke (Cerebral hemorrhage)
(Include pregnancy within 3 months of death)

DURATION
(1) 1 week.
(2) 1 week.
(3) Many years apparently.
(4) Many years.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

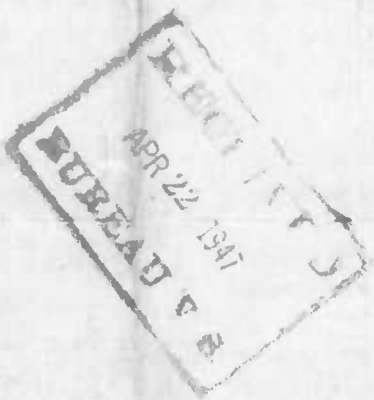
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Norman E. Santomier Jr. M. D. or other
Address: Pocomoke City, Md. Date signed: 18 April 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


APR 22 1941
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

01508

CERTIFICATE OF DEATH

Reg. Dist. No. 361

1. PLACE OF DEATH:

County: Worcester

City or town: Snow Hill Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, Institution, or street address where death occurred: Rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Florida County:

City or town: Sanford

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME Nathan Lewis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col'd	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: about 60 Months: Days: If less than one day: hrs. min.

8. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Labor on Farm

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Mr Thomas J. Johnson

Address: Snow Hill, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 22/47 (month) (day) (year)

Cemetery or crematory: County

Location: Snow Hill, Rural

18. Funeral director: Wday O. Dykes

Address: Snow Hill Md

19. 4/22 1947 (Date rec'd by registrar) L. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 7 19 47, at 4a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Cerebral hemorrhage — DURATION: few minutes

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep Md Exam M. D. or other

Address: Snow Hill Md Date signed: 4/7/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01509

Reg. Diat. No. 355

1. PLACE OF DEATH:
County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Fulton Powell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Cora M. Powell.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1864

8. AGE: Years	Months	Days	If less than one day
82	4	10	..... hrs. ..... min.

9. Birthplace Newark, Wor. Co. Md.
(Town, county, and state)
10. Usual occupation Banker.
11. Industry or business

FATHER
12. Name Robert Martin Powell.
13. Birthplace Maryland.

MOTHER
14. Maiden name Mary E. Flurr Bowen.
15. Birthplace Maryland.

16. Informant Mrs. E. Preston Dashiell.
Address Berlin, Md.

17. B- (Burial, cremation, or removal. Which?) Date thereof 4/6/47 (month) (day) (year)
Cemetery or crematory Bowen.
Location Newark Md.
18. Funeral director Anna A. Burbage
Address Berlin - Md.

19. 4-6 1947 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. [illegible] 1946, to Apr. 3 1947
and that I last saw him alive on Apr. 3 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Done
Date of op.
Autopsy results None Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Nathaniel F. Thomas M.D.
M. D. or other
Address Ocean City, Md. Date signed March 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01510

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Sadie A Powell

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Edward Powell
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Aug 7, 1874
8. AGE: Years 72 | Months 7 | Days 29 | If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housework
FATHER 12. Name: Thomas Dukes
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Ellen Hudson
15. Birthplace: Maryland.
16. Informant: Georgie Hubbard
Address: Whaleyville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8, 1947 (month) (day) (year)
Cemetery or crematory: Whaleyville
Location: Whaleyville Md
18. Funeral director: M. Parks Hatem
Address: Selbyville, Del.
19. 4-8-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1947, at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on ... 19...

	DURATION
Immediate cause of death	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Chr. Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas R. Law M. D. or other
Address: Berlin Md. Date signed 4-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01511

Reg. Diat. No. 3530

1. PLACE OF DEATH:

County: Worcester

City or town: Bishop, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. Md. County: Worcester

City or town: Bishop

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jonathan Savage

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Angie Savage

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 3rd 1871

8. AGE:

Years	Months	Days	If less than one day
75	8	28	hrs. min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James Savage

13. Birthplace: Del.

MOTHER — 14. Maiden name: Mary Lewis

15. Birthplace: Del

16. Informant: Mrs. Jonathan Savage

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 1947 (month) (day) (year)

Cemetery or crematory: Bishopville, Md. Cemetery

Location

18. Funeral director: Henry H. Watson

Address: Pocomoke Md.

19. April 4 1947 Mrs Roy Berger

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1947 at 730 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1947 to April 1st 1947

and that I last saw h[illegible] alive on April 1st 1947

Immediate cause of death	DURATION
[illegible] Thrombosis cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. E. Jones M. D. or other

Address: Selbyville Date signed 4-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

01512

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Worcester.

City or town Berlin.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester.

City or town Berlin.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Willet Taylor.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Helen Taylor.

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1867

8. AGE: Years	Months	Days	If less than one day
79	5	4	...hrs. ...min.

9. Birthplace Brooklyn N. Y. (Town, county, and state)

10. Usual occupation Retired Hatching Mfr.

11. Industry or business

FATHER 12. Name Silas Taylor.

13. Birthplace Maryland.

MOTHER 14. Maiden name Annie M. Willett

15. Birthplace Maryland.

16. Informant Mrs. Harry W. Taylor

Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/47 (month) (day) (year)

Cemetery or crematory Evergreen.

Location Berlin Md.

18. Funeral director Anna N. Burbage

Address Berlin Md

19. 4-4 1947 (Date rec'd by registrar) Helen T. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 1947, to Apr 1 1947.

and that I last saw h.. alive on Apr 1 1947.

Immediate cause of death	DURATION
Cardiac Collapse	
Due to Senility	2 yrs
Due to Atherosclerosis generalisata	
Other conditions Hypertension -	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hermenia Noble Shaw M. D. or other

Address Bay St Date signed 3 Apr 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

01513

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Nancy Evelyn Taylor

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Lee Taylor
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): September 9, 1877

8. AGE:

Years	Months	Days	If less than one day
69	6	26	hrs. min.

9. Birthplace: Parksley, Accomac, Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Revelle Justice
13. Birthplace: Va.

MOTHER
14. Maiden name: Nancy Revelle Littleton
15. Birthplace: Va.

16. Informant: John Taylor
Address: Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1947 (month) (day) (year)
Cemetery or crematory: Liberty Cemetery
Location: Parksley, Va.

18. Funeral director: Margarette H. Watson
Address: Pocomoke city, md.

19. April 7, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947, at 3:A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946, to April 5 1947
and that I last saw her alive on April 4 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to Hypertensive Cardio-Vascular Disease	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis L. Llewelyn, M.D.
M. D. or other
Address: Pocomoke City Date signed 4-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01514

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 151

1. PLACE OF DEATH:
County: Worcester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-American

3.(a) FULL NAME: George H. Townsend

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary H. Townsend
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21 - 1864

8. AGE:

Years	Months	Days	If less than one day
82	10	0	..... hrs. ..... min.

9. Birthplace: Bishop Sussex Delaware
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Josiah Townsend
13. Birthplace: Delaware

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs William Townsend
Address: Newark, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24/47 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Newark, Md
18. Funeral director: Wray E. Timmons
Address: Snow Hill Md

19. 4/24 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 47, at 10 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/17/47 19.. to 4/21/47 19.. and that I last saw h.. alive on 4/21/47 19..

Immediate cause of death	DURATION
Bilateral Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions: Arteriosclerosis	indeterminate
Hypertension Cardio Renal disease	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Paul Cohen M. D.
M. D. or other
Address: Snow Hill Md Date signed 4/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

01515

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4th
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Townsend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frank Townsend
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5, 1870

8. AGE:

Years	Months	Days	If less than one day
76	10	0	..... hrs. ..... min.

9. Birthplace Pocomoke, Worcester, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Roland F. Bevans
13. Birthplace Md

MOTHER
14. Maiden name Sallie E. Powell
15. Birthplace Md.

16. Informant Mrs. Sadie B. Payne
Address Pocomoke city, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof April 8, 1947
(month) (day) (year)
Cemetery or crematory Presbyterian
Location Snowhill, Md.

18. Funeral director Margarette H. Watson
Address Pocomoke city, Md.

19. April 7 1947
(Date rec'd by registrar)
Anne E. White
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946, to April 4 1947
and that I last saw her alive on April 4 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 Days
Due to: Hypertensive Cardio Vasc Disease	5 Yrs
Due to: Senility & Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Louis L. Llewelyn, M.D.
M. D. or other
Address Pocomoke City Date signed 4-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

01516

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Wicomico
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) no
2.(a) If veteran, name war:

3.(a) FULL NAME Lloyd F. Trader

3.(b) Social Security Number none

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie F. Trader
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan. 9 1888

8. AGE: Years: 59 Months: 3 Days: 14 If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Thomas F. Trader
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude E. Powell
15. Birthplace: Maryland

16. Informant: Mrs. Merrill G. Trader
Address: Snow Hill, Md

17. Burial, cremation, or removal. Which? Burial Date thereof: April 26/47 (month) (day) (year)
Cemetery or crematory: Bates Methodist
Location: Snow Hill Md

18. Funeral director: Clay E. Dennis
Address: Snow Hill Md

19. 4/25/47 (Date rec'd by registrar) LeRoy Smith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1947 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to 4/23/47 1947
and that I last saw him alive on 4/23/47 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Hypertensive arteriosclerotic heart disease	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D.
M. D. or other
Address: Snow Hill Md Date signed: 4/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

0151

Reg. Dist. No. 855

1. PLACE OF DEATH:
County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rachael H. P. Warren.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Robert Warren
6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) March 11, 1878.

8. AGE: Years	Months	Days	If less than one day
69	0	26	hrs. min.

9. Birthplace Roxana Delaware
(Town, county, and state)
10. Usual occupation housewife.
11. Industry or business

FATHER
12. Name George A. Harrison
13. Birthplace Delaware

MOTHER
14. Maiden name Mary Catherine Collins
15. Birthplace Delaware

16. Informant Mrs. A. H. Russell
Address Berlin Md

17. Buried Date thereof 4/9/47.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md
18. Funeral director Anne A. Bunting
Address

19. 4-9- 1947 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Apr 1947 at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Feb 1947 to 7 Apr 1947 and that I last saw h[illegible] alive on 7 Apr 47 1947

Immediate cause of death	DURATION
a. Cerebral thrombosis	
Due to Coronary heart disease	2 years
Due to	
Other conditions Cerebral thrombosis	
Cardiosclerosis renal collapse	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Herman A. Rabbitt M.D.
M. D. or other
Address Berlin, Md Date signed 9 Apr 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

01518

CERTIFICATE OF DEATH

Reg. Dist. No. 855

1. PLACE OF DEATH:
County Worcester
City or town Berlin Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION) no
2.(a) If veteran, name war

3.(a) FULL NAME Mary White

3.(b) Social Security Number no

4. Sex: female
5. Color or race: C.A.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Henry White
6.(c) If alive, give age: Don't know years
7. Birth date of deceased (mo., day, yr.): Dec 25, 1861
8. AGE: Years 85 Months 5 Days 2 If less than one day ... hrs. ... min.
~~Dec 1862~~
9. Birthplace: Berlin Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Same as above
FATHER 12. Name: George Henry
FATHER 13. Birthplace: Berlin Md
MOTHER 14. Maiden name: Charlott Timmons
MOTHER 15. Birthplace: Berlin Md
16. Informant: Henry White
Address: Berlin Md
Apr 30-47
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30 1947
Cemetery or crematory: Evergreen
Location: Berlin Md
18. Funeral director: James A. Stewart
Address: Salisbury Md
19. Apr 30 1947 (Date rec'd by registrar) Helen E. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw ... alive on April 26 1947
Immediate cause of death

DURATION

Due to: Carcinoma of Uterus
Due to:
Other conditions: Chr. Nephritis
(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R. Low M.D. M. D. or other
Address Berlin Md Date signed 4-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 ...45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

01519

Reg. Dist. No. 3500

1. PLACE OF DEATH:
County Worcester
City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Amanda Wise

3.(b) Social Security Number ✓

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: George Wise
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 5, 1879

8. AGE:

Years	Months	Days	If less than one day
68	8	28	... hrs. ... min.

9. Birthplace: Pocomoke, Worcester, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ✓

FATHER
12. Name: William Ballard
13. Birthplace: Md.

MOTHER
14. Maiden name: Rosie Gumby
15. Birthplace: Md.

16. Informant: Willie Wise
Address: R. F. D. Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6, 1947 (month) (day) (year)
Cemetery or crematory: Wardtown Cemetery
Location: New Church, Va.

18. Funeral director: Henry H. F. Watson
Address: Pocomoke City, Md.

19. April 5, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1947, to April 3 1947
and that I last saw her alive on April 3 1947

Immediate cause of death	DURATION
Apoplexy	10 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE C. L. Pitcher M. D. or other M.D.
Address New Church, Va. Date signed 4-4-47